UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

Oralair Immunotherapy

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

- Client must be between 10 and 65 years of age.
- Provide documentation of a grass pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in Oralair: Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens
- Therapy must be initiated at least 12 weeks before the expected onset of each grass pollen season. (December 5 to January 10)
- First dose must be administered under supervision of a physician with experience in the diagnosis and treatment of allergic diseases. Letter of medical necessity or progress notes must document that patient will be observed, in the office for at least 30 minutes following the initial dose.

AUTHORIZATION: One year

RE-AUTHORIZATION: Three consecutive years

- Client age between 10 and 65 years of age.
- Initial therapy was approved and initiated at least 12 weeks prior to expected onset of grass pollen season.
- Therapy has been continuous throughout grass pollen season.